

FILED JUN 7 1945

Registration District No. 108

Primary Registration District No. 5423

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Arbyrd  
*Salmon Brook*

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dunklin

(c) City or town Arbyrd  
*(If outside city or town limits, write "RURAL")*

(d) Street No. .... (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME John W(initial)Wilmoth

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced. married

6. (b) Name of husband or wife Vina Wilmoth

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased May 10, 1870  
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 15

If less than one day: hr. .... min.

9. Birthplace Unknown Ark.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business .....

12. Name Unknown

13. Birthplace .....

14. Maiden name Unknown

15. Birthplace .....

16. (a) Informant A. W. Wilmoth

(b) Address Arbyrd, Mo.

17. (a) Burial (b) Date thereof 5-26-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Senath Mo. Burial Cemetery

18. (a) Signature of funeral director W. N. Neward

(b) Address Leachville, Ark.

19. (a) 6-4-1945 (b) D. C. Steacy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25th  
year 1945 hour 6 minute A.M.

21. I hereby certify that I attended the deceased from May 24, 1945, to May 24, 1945;  
that I last saw him alive on May 24, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis and myocardial degeneration

Duration DK

Due to .....

Due to .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings: ABO

Of operations .....

Of autopsy .....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) .....

(b) Date of occurrence .....

(c) Where did injury occur? .....

(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? .....

(Specify type of place) (e) Means of injury .....

23. Signature M. C. Glasgow (M. D. or other) Cardwell  
Address .....

Date signed 6-4-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

351  
6-45

12710

JUN 8 1965

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *W. H. Howard* .....

Licensed Embalmer No. *3959* .....

P. O. Address *Leachville, Ark.* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.